chemical basis for the preferential impairment of hemostasis in hemophiliac patients, we might anticipate that patients with acquired bleeding disorders will experience a similar hemorrhagic tendency. Among those infected with HIV, such disorders could include idiopathic thrombocytopenia, chemotherapy-induced thrombocytopenia or the hemostatic deficiencies associated with liver disease.

Hemophiliac patients should be closely questioned for any change in their usual bleeding pattern while they are receiving protease inhibitors, as should any patients with other congenital or acquired hemostatic disorders.

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Applause for Dr. Romalis

Dr. Garson Romalis, whose story is told in the article "7:10 am, Nov. 8, 1994" (*CMAJ* 1998;158[4]: 528-31), by Anne Mullens, deserves applause. His courage in defending his beliefs and his vision for the future of abortion in Canada can at the very least be described as commendable but is probably more suitably characterized as inspirational. As an idealistic young man on the brink of his medical career, I too am drawn to obstetrics and gynecology. However, Romalis's ordeal leaves me asking why I should bother. When there are so many other ways to help my fellow human beings, why put my life on the line? For me the answer is clear: I hope I never have to practise medicine in a Canada where abortion is illegal.

The rewards of bringing a healthy, wanted child into the world are mirrored by the satisfaction of providing an essential and safe service to desperate young women. I have never assisted in more than the evacuation of an incomplete spontaneous abortion, and this means that I have not yet personally grappled with the emotional impact of the procedure. However, I have looked into the eyes of a distressed patient and seen the need. I may soon follow in the footsteps of "our greying abortion providers" and will actively support an educational symposium at McGill that is similar to the one described in this article.

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Advance directives for insulin-using diabetic patients

Advance directives are instructional comments written by a patient to guide health care professionals in the future health care of that patient and to designate proxy decision-makers should the patient become incompetent. The increasing use of advance directives is now governed by legislation in both Canada and the US.[1,2] Although most end-of-life treatment planning has been done in hospital, it seems that the outpatient setting provides a calmer atmosphere for this activity.[3]

Little has been written about the use of advance directives by patients with diabetes. We asked 27 insulin-using diabetic outpatients of both sexes (aged 18 to 70 [mean 49] years) to complete a questionnaire on demographic characteristics and their current knowledge of, attitudes about and behaviours regarding advance directives. The patients and their physicians also rated the patients' quality of life using Cantril's Self-Anchoring Striving Scale[4] and the patients' state of health on a numeric scale ranging from 1 (excellent) to 5 (poor). Half of the participants were then randomly assigned to participate in an education program on advance directives, which included a discussion and question period with a health care professional, an information pamphlet and a video entitled *My Health Care — I Decide*.[5] Four to 6 weeks later the patients were asked to complete a follow-up questionnaire.

All of the patients indicated that it was either extremely important or very important that they have a say in what type of health care they received. Eighty-nine percent of the patients believed that the best time to discuss their wishes was when they were well, during a routine visit. Thirteen percent of the patients reported at the outset of the program that they already had a directive. Those who participated in the education program showed increased knowledge of advance directives and reported increased discussion of their wishes with their family members and physicians. When patients were contacted 2 years later, 30% had actually completed an advance directive.

This small group of diabetic patients demonstrated a readiness to discuss advance directives with health care professionals *in the outpatient setting*, an approach that has been advocated as sensible and potentially cost effective.[1] Given that diabetic patients have significant and often predictable illness, specialist caregivers should be

encouraged to develop advance directives with their patients during routine visits, free from the pressures of the acute care setting.

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Breast cancer guidelines

All physicians will be grateful to Dr. Maurice McGregor and his many colleagues on the Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer for their prodigious effort in producing the supplement "Clinical practice guidelines for the care and treatment of breast cancer: a Canadian consensus document" (*CMAJ* 1998;158[3 Suppl]:S1-83). My remarks should be considered a part of the refinement process that now begins.

Page S5, in guideline 1, "The palpable breast lump: information and recommendations to assist decision-making when a breast lump is detected" (*CMAJ* 1998;158[3 Suppl]: S3-8), emphasizes that physicians can often distinguish, by clinical examination, benign from malignant breast lumps and that practice improves performance. Unfortunately, "often" is not good enough for Canadian women. The clinical examination can never reach the level of accuracy of the gold standard, excisional biopsy. Timely access to excisional biopsy is available to everyone in Canada, with the possible exception of those living in remote communities.

Canadian women will accept nothing less than the gold standard. Canadian physicians and surgeons should insist on the same and may be penalized if they provide anything less.[1]

Somewhere on page S5 the following message should be prominently displayed: "Any clinically palpable lump (mass lesion) that is solid on aspiration must ultimately be proven to be cancer or not cancer by excisional biopsy." This recommendation applies to all lumps, even apparently typical fibroadenomas in adolescents and women in their early 20s, because breast cancer does occur — if only rarely — in these age groups. Excisional biopsy could save many physicians and patients a lot of grief.

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I read with interest the consensus guideline "Investigation of lesions detected by mammography" (*CMAJ* 1998;158[3 Suppl]:S9-14). I was involved in the peer review of this document and raised certain concerns at that time. Although the authors addressed some of my comments, a few problems have remained unanswered.

- On page S11 it is stated that "[i]n all but completely straightforward cases . . . the opinion should be obtained of a second radiologist who is also experienced in mammographic interpretation (level V evidence [i.e., opinion of the guideline authors])." There are no studies to support any benefit from such an approach. I remember that the Canadian National Breast Screening Study (NBSS) followed such a policy, but in my own experience, 2 cases that I identified and that were not confirmed by another radiologist were found to be cancer at the next screening. The authors allude to 2 references,[1,2] both of which apply to double reading of *all* cases, not only the doubtful ones. I am certain that the routine checking of only doubtful mammograms by a second experienced radiologist will decrease the breast cancer detection rate, even though it may cut back on recalls.
- In the section on the report of mammographic work-up (p. S11), 4 categories of risk stratification are presented. It is stated that the classification is similar to that of the American College of Radiology (ACR). However, the ACR classification has 5 categories, category 1 representing normal results. Eliminating the "normal" category changes the risk value of the others: category 3 in the ACR classification signifies probably benign lesions, whereas here it refers to probably malignant lesions. Given that the ACR system is an internationally accepted categorization, it is confusing and possibly dangerous to change the numeric assignment of the categories.
- The discussion of attribution of a numeric percentage risk within categories is confusing. Page S11 states that the percentage has "no precise quantitative meaning and is intended only to give meaning to the expressions 'low,' 'intermediate' and 'high' risk," yet on page S12 for category 3 abnormalities it is stated that to perform a biopsy,